that should go beyond a mere symptom checklist. Psychiatry, like other branches of medicine, is an art form that applies science in practice. The classical art of psychiatry has not been "cool" for a long time; the focus of the "clinical" psychiatry training curriculum should, nevertheless, be on psychiatric interview skills and clinical reasoning based on the characterization, until research delivers algorithms that can support or automate parts of the clinical reasoning.

One shall collaborate to alternate. Academic psychiatry should invite a wide range of stakeholders (e.g., patients, their families, carers, mental health practitioners, and policy makers) to actively take part in this process from the beginning, by identifying key issues and proposing solutions to meet the needs of our society.

Until convincing evidence is provided, the current classification system is unlikely to be superseded by the proposed alternatives for use in clinical practice. In the meantime, the above adjustments may help to overcome the issues arising from diagnostic silos in psychiatry.

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Managing dual disorders: a statement by the Informal Scientific Network, UN Commission on Narcotic Drugs

Since 2015, the United Nations Office on Drugs and Crime (UNODC) – World Health Organization (WHO) Informal Scientific Network has strived to bring the voice of science as it pertains to drug use disorder treatment and care, to inform critical discussions at the Commission on Narcotic Drugs, the policy-making body of the United Nations (UN) with prime responsibility for drug control matters. In recent years, the public health dimensions of the world drug problem, including prevention and treatment of drug use disorders, have become prominent in policy debates within the UN system[1].

Drug use disorders can have devastating consequences for affected individuals, their families and communities. They are associated with lost productivity, security challenges, crime, and myriad negative health and social consequences. Caring for and treating individuals with drug use disorders exacts a heavy toll on the public health networks of UN Member States. Availability of effective treatments for these disorders is very limited, and far from achieving the universal health coverage target set in the Sustainable Development Goals 2030.

This situation is further exacerbated by the frequent co-occurrence of drug use disorders with other mental health conditions (dual disorders)[2], a phenomenon associated with increases in emergency department admissions[3] and psychiatric hospitalizations[4], higher risk of relapse to drug use[5], and increased likelihood of premature deaths[6], including those resulting from suicide[7]. The individual, social and public health impact of dual disorders is very high, and a multidisciplinary and comprehensive response to the needs of persons with these disorders is required. Unfortunately, there are many gaps in the global system, which is ill prepared to meet this challenge.

Lack of attention is driven in part by lack of training of clinicians on how to diagnose and treat dual disorders, as well as by the structural differentiation and lack of coordination, in many countries, between programs to treat drug use disorders and those to treat mental illnesses. Other contributing factors include "diagnostic overshadowing"[8], whereby individuals suffering from a drug use disorder and a comorbid mental illness have their morbidity frequently attributed to the former, potentially neglecting the contribution from mental health (and somatic) conditions. Such neglect is partly due to the implicit bias and discrimination towards drug use disorders and the lack of familiarity of the provider with the condition that receives the attribution.

Another contributing factor is the "wrong door syndrome"[9], which connotes the difficulty not only for treating but also for diagnosing drug use disorders among mental and medical treatment services and vice versa. Furthermore, people with dual disorders are often excluded from studies on effectiveness of treatment interventions, which hampers the development of evidence-based recommendations for treatment of these patients.

The examples highlighted above are just some of the many systemic challenges that the Informal Scientific Network considered during its recent discussions to craft evidence-based guidance for national health systems interested in developing coordinated, multiple system-level interventions to address the unmet needs of people affected by dual disorders.

The following recommendations reflect the unanimous consensus reached by the Network membership during those discussions:

- Dual disorders must be addressed as an integral part of universal health coverage.
- Policy-makers should devise strategies to address the com-

mon biopsychosocial factors that are associated with the development of dual disorders.
- The high prevalence and related disability of dual disorders require active intervention from policy-makers at a systems level and active advocacy from health professionals.
- Service providers should be trained in the management of dual disorders and sufficient financial support should be granted for this purpose.
- Systematic screening for other mental disorders through validated instruments by trained health service providers is an essential component of adequate care for people with drug use disorders.
- Availability of and accessibility to adequate treatment should be provided, regardless of the entry point to care systems, in line with the principle of "no wrong door".
- Sex- and gender-based knowledge and a stigma-free approach are required in the effective management of dual disorders.
- Age-specific interventions are required across the lifespan, especially for minors and the elderly.
- Science-informed prevention interventions that address common risk factors, such as early life adversity, should be available to children living with parents and/or caregivers with dual disorders.
- Attention should also be given to other at-risk and vulnerable populations, in accordance with local needs.
- Access to services for dual disorders in the criminal justice system, particularly in prison settings, youth detention or correctional centres, should be secured.
- Collection and analysis of data to monitor the magnitude of the problem, the quality of care and the outcomes of policies and interventions should be encouraged.
- Implementation and scale up of effective and efficient interventions, with consideration of cultural and country specificities, is a priority.
- Finally, the Informal Scientific Network urges UN Member States to further support scientific research on new and enhanced interventions to effectively prevent and treat psychiatric comorbidities in people with drug use disorders.

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A 16-year follow-up of patients with serious mental illness and co-occurring substance use disorder

Individuals with serious mental illnesses, such as schizophrenia and bipolar disorder, experience high rates of co-occurring substance use disorders (approximately 41% across many studies)[1]. Patients with these co-occurring disorders are prone to a range of short-term adverse outcomes: relapses, hospitalizations, violence, homelessness, incarceration, family problems, suicide, and serious medical illnesses such as HIV and hepatitis C[2]. Despite these negative prognostic indicators, few studies have addressed the long-term course of patients with co-occurring disorders.

We previously reported on a cohort of such patients in New Hampshire who were followed prospectively for 10 years[3,4]. Our follow-up study showed that those who avoided early mortality tended to improve steadily over time, not only in terms of psychiatric symptoms and substance abuse, but also in functional areas such as independent living and employment. The present report extends the follow-up of the New Hampshire cohort to 16 years.

A grant from the Robert Wood Johnson Foundation facilitated implementation of integrated treatment services for patients with co-occurring disorders in New Hampshire in 1988. The integrated services included residential dual-diagnosis treatment, assertive community treatment teams, dual-diagnosis groups, illness management training, family psychoeducation, supported employment, and other evidence-based practices. A subsequent grant from the National Institute of Mental Health extended the follow-up of these patients prospectively for 16 years.

At baseline and yearly thereafter, our interviewers assessed 223 adults with co-occurring serious mental illness (schizophrenia spectrum or bipolar disorder) and substance use disorder (predominantly alcohol and cannabis) in New Hampshire, which is a rural Northeast state in the US. We used standardized measures, described elsewhere in detail[3], to assess diagnoses, psychiatric symptoms, substance abuse, independent living, competitive employment, social supports, and quality of life.